SA Health Infection Control Service

Infection Prevention and Control: Exemplar Audits to support the National Safety and Quality Health Service (NSQHS) Standards

Tool kit

Version 2.6

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Government of South Australia
SA Health

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Introduction

The Australian Commission on Safety and Quality in Health Care (ACSQHC) National Safety and Quality Health Service (NSQHS) Standards, Preventing and Controlling Infections requires health service organisations develop, implement, and monitor systems to manage and control infections. Local Health Networks (LHN) should ensure the implementation of ACSQHC resources and guides (including Accreditation Guides) are part of achieving compliance with the mandatory NSQHS Standards.

The SA Health Infection Control Service (ICS) audit toolkit aims to provide additional exemplar audit tools which may be of additional assistance to health facilities as part of the provision of evidence of actions relating to the ACSQHC NSQHS Standards, Preventing and Controlling Healthcare Associated Infections.

The audit tool kit is provided by the ICS as example of audits and are not mandatory under SA Health governance requirements. LHNs can modify the audit tools as required. Instructions for use are described for each individual audit tool.

LHNs should have local policies, procedures and/or protocols that are regularly monitored, and reports generated that show the results of any process audits conducted. The review of audit results may aid in the development of action plans to improve processes, if required. Audit results should be reported to staff and appropriate local governance committees.

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NSQHS Standard Criterion: Clinical governance and quality improvement systems are in place to prevent and control healthcare-associated infections, and support antimicrobial stewardship and sustainable use of infection prevention and control resources

1. Audit: Healthcare worker knowledge of infection prevention and control

Objective: To identify the level of knowledge of infection prevention and control principles amongst clinical staff

Ward or unit area: ..... **Total number of staff observed:**

Assessor: ..... Date: .....

Instructions for use: It is recommended that a sample of between 5 and 10 subjects are audited using the tool. The audit tool is designed to audit **clinical staff** only. Expected answers are in *italics*. (Fill in the point score for each question in the appropriate box).

Professional group - allied health (AH), doctor (Dr), nurse/midwife (NM), student allied health (SAH), student doctor (SDr), student nurse/midwife (SNM)	**HCW 1**	**HCW 2**	**HCW 3**	**HCW 4**	**HCW 5**	**HCW 6**	**HCW 7**	**HCW 8**	**HCW 9**	**HCW 10**	**Result per topic**
Type of HCW professional:											
1. HCW can articulate knowledge of standard & transmission-based precautions. Ask the following questions:											
1.1 When are standard precautions used? *When there is a risk of exposure to blood or body fluids and to minimise the risk of transmission of healthcare associated infection – 1 point*											
1.2 What practices do standard precautions include? *Hand hygiene; aseptic technique; equipment cleaning & reprocessing; environmental cleaning; appropriate use of PPE; safe handling of sharps; waste & soiled linen – 1 point each (Up to 8 points total)*											
1.3 What PPE is required for: a) Contact precautions *Gloves, gown and/or apron (2½ points total)*											
b) Droplet precautions *Surgical mask – ½ point. Eye protection (safety glasses/goggles or face shield)- ½ point*											
c) Airborne precautions *Particulate Filter Respirator (PFR) – (i.e. P2/N95 or equivalent) – ½ point and Eye protection (safety glasses/goggles or face shield)-½ point*											

Professional group - allied health (AH), doctor (Dr), nurse/midwife (NM), student allied health (SAH), student doctor (SDr), student nurse/midwife (SNM)	**HCW 1**	**HCW 2**	**HCW 3**	**HCW 4**	**HCW 5**	**HCW 6**	**HCW 7**	**HCW 8**	**HCW 9**	**HCW 10**	**Result per topic**
Type of HCW professional:											
1. Sub-total (out of 14)											
2. HCW can articulate knowledge regarding the management of multi-resistant organisms. *Single room; contact precautions; hand hygiene; cleaning of environment & patient equipment – 1 point each* *(Up to 5 points total)*											
3. HCW can articulate knowledge regarding the importance of immunisation *HCWs have an increased exposure risk to vaccine preventable diseases; may transmit infections to susceptible patients – 1 point each* *(Up to 2 points total)*											
4. HCW knows where to locate local infection prevention & control policies, procedures and general information on infectious diseases - *1 point*											
5. HCW knows how to contact their Infection Prevention & Control Unit or representative - *1 point*											
Q 2-5. Sub-total (out of 9)											
Total Score per HCW	**/ 23**	**/ 23**	**/ 23**	**/ 23**	**/ 23**	**/ 23**	**/ 23**	**/ 23**	**/ 23**	**/ 23**	

Feedback / Comments

Overall level of knowledge = ... %

$$\frac{\text{total number of points}}{\text{maximum number of points possible}} \times 100 = xx\%$$

(i.e. number of HCW tested x 23)

NSQHS Standard Criterion: Clinical governance and quality improvement systems are in place to prevent and control healthcare-associated infections, and support antimicrobial stewardship and sustainable use of infection prevention and control resoures

2. Audit: LHN compliance with national and state surveillance requirements as outlined on the *SA Health Healthcare-Associated Infection Surveillance webpage*

Objective: To identify Local Health Network (LHN) compliance as per National and SA Health *Healthcare Associated Infection (HAI) Surveillance Requirements*

Ward or unit area: .....

Assessor: ..... Date: .....

Instructions for use: It is recommended that a sample of 5 to 10 ward areas are audited using this audit tool.

Y = compliant with criteria; N = not compliant with criteria (Fill in Y or N as appropriate).

Policy Statement:

Reliable surveillance data underpin all quality improvement processes, and regular monitoring and feedback is associated with improved patient outcomes. An effective surveillance system is one that delivers timely information to drive change and to evaluate the effectiveness of interventions.

The SA Health *Healthcare Associated Infection Surveillance Program* formalises hospital surveillance monitoring.

Questions	Compliance	Links to evidence if available electronically
1. The LHN has a process in place for identification of laboratory results relevant to collecting information for the SA Health healthcare-associated infection (HAI) program.		
2. The LHN has a documented HAI surveillance procedure or manual (including data collection forms and tools).		
3. The LHN undertakes data quality checks and validation prior to reporting to local and statewide data collections.		
4. The LHN uses state and national standardised surveillance definitions.		
5. The LHN can demonstrate evaluation and use of surveillance data prior to, and post practice change/s designed to reduce the risks associated with HAI.		
6. The LHN can demonstrate action/s taken when an increase in HAI is identified.		
7. The LHN has documentation from relevant committees/meetings indicating that HAIs are reported within the organisation.		

Questions	Compliance	Links to evidence if available electronically
8. Regular reports are generated for executive, departments and staff (including trends over time & outbreak or intervention specific data).		
9. HAI surveillance reports are available to consumers and other relevant groups.		
10. HAI surveillance data are provided to the state Infection Control Service in accordance with the SA Health HAI Surveillance Program.		
Total score	**/ 10**	
Feedback / Comments	**Score for compliance = …... %** total number of Yes answers / maximum number of points possible x 100 = xx%	

NSQHS Standard Criterion: Clinical governance and quality improvement systems are in place to prevent and control healthcare-associated infections, and support antimicrobial stewardship and sustainable use of infection prevention and control resources

3. Audit: Ward compliance awareness of National and *SA Health Healthcare Associated Infection (HAI) Surveillance Program Requirements*

Objective: **To identify ward compliance awareness of data as per National and SA Health *Healthcare Associated Infection Surveillance Requirements***

Ward or unit area: .....

Assessor: ..... Date: .....

Instructions for use: It is recommended that a sample of 5 to 10 wards areas are audited using this audit tool; **one sheet per ward**. The audit tool is designed to audit **clinical staff only.**

Y = compliant with criteria; N = not compliant with criteria (Fill in Y or N as appropriate).

Policy Statement:

Reliable surveillance data underpins quality improvement processes, and regular monitoring and feedback may be associated with improved patient outcomes. An effective surveillance system is one that delivers timely information to drive change and to evaluate the effectiveness of interventions.

Questions										**Compliance**
Circle Y or N as appropriate										
1. Have you seen any HAI surveillance data/reports specific to your ward in the last 3 months? **Ask 5 HCWs**. (circle Y or N)										
HCW 1		**HCW 2**		**HCW 3**		**HCW 4**		**HCW 5**		
Y	N	Y	N	Y	N	Y	N	Y	N	
2. Are you aware of your ward's HAIs rate/s? For example SAB, MRO, and / or surgical site infection? **Ask 5 HCWs**. (circle Y or N)										
HCW 1		**HCW 2**		**HCW 3**		**HCW 4**		**HCW 5**		
Y	N	Y	N	Y	N	Y	N	Y	N	
3. Do you know where to find local HAI surveillance results? **Ask 5 HCWs.** (circle Y or N)										
HCW 1		**HCW 2**		**HCW 3**		**HCW 4**		**HCW 5**		
Y	N	Y	N	Y	N	Y	N	Y	N	
								Total score		**/ 15**

Feedback/comment:	**Score for compliance = ……%** total number of yes answers / total number of yes and no responses x 100 = xx%

NSQHS Standard Criterion: Infection prevention and control systems and Clinical governance and quality improvement systems are in place to prevent and control infections, and support antimicrobial stewardship and sustainable use of infection prevention and control resources

4. Audit: Ward compliance is consistent with the National Hand Hygiene Initiative (NHHI)

Objective: **To assess alcohol-based hand rub (ABHR) is available at point of care and that the product has not expired**

Ward or unit area: .....

Assessor: ..... Date: .....

Instructions for use: Audit key areas & each bed to identify whether ABHR is available & that it is fit for purpose (i.e. not expired or empty).
Y = available & has not expired, N = not available or has expired. (Fill in Y or N as appropriate)

Bed Number	ABHR available at point of care	ABHR has not expired	Bed Number	ABHR available at point of care	ABHR has not expired
1			20		
2			21		
3			22		
4			23		
5			24		
6			25		
7			26		
8			27		
9			28		
10			29		
11			30		
12			31		
13			32		
14			33		
15			34		
16			Treatment room		
17			Medication room		
18			Nurses Station		
19			Dirty Utility		
Feedback / Comments			**Score for compliance = …... %** total number of Yes answers / total number of beds & areas audited x2 x 100 = xx%		

Optional: Check at the entrance to your facility or ward for ABHR availability and expiry.

NSQHS Standard Criterion: Infection prevention and control systems

5. Audit: Healthcare worker compliance is consistent with the National Hand Hygiene Initiative (NHHI)

Objective: To identify the percentage of clinical staff / health care workers (HCW) who are consistent with the NHHI

Ward or unit area: ..... **Total number of staff observed:**

Assessor: ..... Date: .....

Instructions for use: It is suggested that a sample of between 5 and 10 subjects are audited using the tool. This audit tool is designed to audit **clinical staff only.**

Y = HCW complies, N = HCW does not comply. (Fill in Y or N as appropriate in each box).

Professional group - allied health (AH), doctor (Dr), nurse/midwife (NM), student allied health (SAH), student doctor (SDr), student nurse/midwife (SNM), * domestic (D), **personal care staff (PC), other (O).	HCW 1	HCW 2	HCW 3	HCW 4	HCW 5	HCW 6	HCW 7	HCW 8	HCW 9	HCW 10	Result per topic
Type of HCW professional:											
1. HCW has short, clean fingernails?											
2. HCW does not wear acrylic (false) nails											
3. HCW does not wear nail polish											
4. HCW is not wearing a wristwatch											
5. HCW is not wearing a bracelet (medical alert may need to be worn elsewhere other than wrist)											
6. HCW is not wearing rings (1 plain band acceptable)											
7. Hand hygiene competency has been assessed using ABHR											
8. Hand washing competency has been assessed using soap and water											
9. HCW can state the HHA auditing program implemented in their area/organisation (^ see next page additional info)											
Total Score per HCW	**/ 9**	**/ 9**	**/ 9**	**/ 9**	**/ 9**	**/ 9**	**/ 9**	**/ 9**	**/ 9**	**/ 9**	

*Domestic includes catering, cleaners and maintenance.

** Personal care staff includes Personal Care worker, Patient Services Assistant, Assistant in Nursing, orderly and wardsman.

Feedback / Comments	**Overall compliance score = ……%** $\frac{\text{total number of yes answers}}{\text{total number of yes \& no answers x no. of staff audited}}$ x 100 = xx%	**Percentage of staff that fully comply = ……%** $\frac{\text{total number with perfect scores}}{\text{total number of staff audited}}$ x100 = xx%

^ Hand hygiene compliance tools recommended by SA Health - National Hand Hygiene Initiative (NHHI) 5 moments or SA Health Hand Hygiene Observational Tool

NSQHS Standard Criterion: Infection prevention and control systems

6. Audit: Healthcare worker competency in donning (putting on) & doffing (taking off) personal protective equipment

Objective: To identify the percentage of health care workers (HCW) who are competent in donning & doffing personal protective equipment (PPE)

Ward or unit area: ..... **Total number of staff observed:**

Assessor: ..... Date: .....

Instructions for use: It is recommended that a sample of between 5 and 10 audits are completed using the audit tool. The audit tool is designed to audit **any HCW**.

Y = HCW complies, N = HCW does not comply. (Fill in Y or N as appropriate in each box).

Also refer to the SA Health Training Tool for the Use of PPE and Respirator Fit Testing Tool.

Professional group - allied health (AH), doctor (Dr), nurse/midwife (NM), student allied health (SAH), student doctor (SDr), student nurse/midwife (SNM,), * domestic (D), **personal care staff (PC), other (O).		HCW 1	HCW 2	HCW 3	HCW 4	HCW 5	HCW 6	HCW 7	HCW 8	HCW 9	HCW 10	Result per topic
Type of HCW professional:												
Donning												
1. Perform hand hygiene	Either alcohol-based hand rub or hand wash											
2. Put on disposable gown	Both ties at the back of the gown have been secured											
3. Correctly put on surgical mask or particulate filtration respirator (PFR)	Surgical or PFR (i.e.P2/N95 or equivalent) – fitted correctly, fit check performed											
4. Put on eye protection - (goggles, safety glasses or face shield)	Eye protection put on correctly (***Note***: must be applied in addition to prescription glasses)											
5. Put on gloves	Put on gloves ensuring the gown cuffs are covered by the gloves											

*Domestic includes catering, cleaners and maintenance.

** Personal care staff includes Personal Care worker, Patient Services Assistant, Assistant in Nursing, orderly and wardsman

Professional group - allied health (AH), doctor (Dr), nurse/midwife (NM), student allied health (SAH), student doctor (SDr), student nurse/midwife (SNM), * domestic (D), **personal care staff (PC)., other (O).		HCW 1	HCW 2	HCW 3	HCW 4	HCW 5	HCW 6	HCW 7	HCW 8	HCW 9	HCW 10	Result per topic
Type of HCW professional:												
6. PPE check	Check all items of PPE are correctly in place											
Donning sub-total per HCW		**/ 6**	**/ 6**	**/ 6**	**/ 6**	**/ 6**	**/ 6**	**/ 6**	**/ 6**	**/ 6**	**/ 6**	

Doffing												
1.1 Remove gloves using correct procedure	One glove is removed & scrunched into other hand. The other glove is then removed by pulling over the held glove, so it is inside out											
1.2 Dispose of gloves	The gloves are placed **carefully** into the bin (not flicked)											
2. Perform hand hygiene	Either alcohol-based hand rub or hand wash											
3.1 Remove gown	The gown is removed by folding away from the body with only the clean inner side of the gown being exposed											
3.2 Dispose of gown	Placed **carefully** in a general waste bin											
4. Perform hand hygiene	Either alcohol-based hand rub or hand wash											
5.1 Remove eye protection	Remove using the arms of the goggles, safety glasses or face shield											
5.2 Dispose of eye protection	Place in designated container for reprocessing or in a waste container											
6. Perform hand hygiene	Either alcohol-based hand rub or hand wash											

7.	Remove mask / respirator (if applicable)	Mask is removed by the straps and **carefully** placed in general waste bin (outside of room)										
8.	Perform hand hygiene	Either alcohol-based hand rub or hand wash										
		Doffing sub-total per HCW	**/ 11**	**/ 11**	**/ 11**	**/ 11**	**/ 11**	**/ 11**	**/ 11**	**/ 11**	**/ 11**	**/ 11**	
		Total score per HCW (putting on & taking off)	**/ 17**	**/ 17**	**/ 17**	**/ 17**	**/ 17**	**/ 17**	**/ 17**	**/ 17**	**/ 17**	**/ 17**	

Action item 3.07: **HCW Compliance in donning & doffing personal protective equipment (PPE)**	**Overall compliance score = ……%** $\frac{\text{total number of correct steps}}{\text{total number of steps assessed}}$ x100 = xx% (*i.e. number of HCW assessed x 14)*	**Percentage of staff that fully comply = ……%** $\frac{\text{total number of perfect scores}}{\text{total number of staff audited}}$ x100 = xx%
Feedback / Comments		

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NSQHS Standard Criterion: Infection prevention and control systems

7. Audit: LHN compliance with Aseptic Technique

Objective: To identify LHN compliance with Aseptic Technique (AT)

Assessor: ..... Date: .....

Instructions for use: It is recommended that the Local Health Network assess the questions / compliance statements outlined in this audit tool and report the audit results to staff and appropriate governance committee/s.

Y = compliant with criteria; N = not compliant with criteria (Fill in Y or N as appropriate).

Questions / Compliance statements	Compliance	Links to evidence and resources if available electronically
1. The LHN has a documented aseptic technique clinical procedure / work instruction.		
2. The LHN has identified the procedures that require aseptic technique.		SA Health aseptic technique resources
3. The LHN has a documented record that includes the number and names of staff who have completed aseptic technique training.eg SA Health Aseptic Technique e-learning module, Staff training and self-assessment workbook: aseptic technique		SA Health aseptic technique resources
4. The LHN has a documented record of the number of clinical staff who have completed relevant aseptic technique competencies.		
5. Aseptic technique process and competency audits are undertaken as per the facilities audits schedule and results are reported to staff and at appropriate governance committees.		
6. Actions are taken by the LHN to reduce identified risks associated with aseptic technique. eg An action plan identifies risks from training reports, competency reports and audit results and documents progress and improvements.		
Total Score	**/6**	

Feedback / Comments	**Score for compliance = …... %** total number of Yes answers / maximum number of points possible x 100 = xx%

NSQHS Standard Criterion: Infection prevention and control systems

8. Audit: Compliance with the use and management of invasive devices: intravascular devices

Objective: To identify staff compliance with maintenance of intravascular devices

Instructions for use: It is recommended that a sample of 5 to 10 audits (1 patient per audit sheet) are completed using the audit tool. The audit tool is designed to audit **patients with an IVD.**

Y = complies, N = does not comply.

Patient UR: .....

Ward or unit area: ....

Assessor: .... Date: .....

Type of devices Circle applicable device type						**Site of device** Circle applicable site								**No. of insertion attempts**	
PIVD	**CVC**	**PICC**	**Vas-cath**	**Arterial line**	**Swan Ganz**	**Hand**	**Cubital fossa**	**Forearm**	**Wrist**	**Intra-jugular**	**Subclavian**	**Femoral Cubital fossa**	**Other:____**	(Record number if information available)	
Circle Y or N as appropriate for each question															
1. Is there documentation in the case notes, i.e. insertion date, site, and type?														Y	N
2. Is there documentation in all other relevant files, i.e. case notes, nursing care plan, electronic notes?														Y	N
3. Is there a record of observation/ maintenance of the device at a minimum, each shift?														Y	N
4. Is a recommended cannulation site chosen?														Y	N
5. Is a recommended dressing used?														Y	N
6. Is there a date & time on dressing?														Y	N
7. Is the dressing dry and intact?														Y	N
8. The insertion site is clean and dry with no sign of phlebitis or infection														Y	N
9. Has the patient been provided with information e.g. Consumer Information Sheet?														Y	N
Total score														**/ 9**	**/ 9**
10. Has the PIVD been *in situ* for i.e < 72 hours? Is there a documented risk assessment for extended dwell time(Refer to LHN Policy and the ACSQHC Management of Peripheral Intravenous Catheters Clinical Care Standard														Y	N
***if question 10 answered adjust total score														**/ 10**	**/ 10**
Feedback/comment						**Score for compliance = ……%** total number of yes answers / total number of questions x 100 = xx%									

NSQHS Standard Criterion: Infection prevention and control systems

9. Audit: Compliance with the use and management of invasive devices: indwelling urinary catheter

Objective: To identify staff compliance with maintenance of indwelling urinary catheters

Instructions for use: It is recommended that a sample of 5 to 10 audits (1 patient per audit sheet) are completed using the audit tool. The audit tool is designed to audit **patients with an indwelling urinary catheter.**

Y = complies, N = does not comply.

Patient UR .....

Ward or unit area: .....

Assessor: ..... Date: .....

Indwelling urinary device site (tick applicable)	**Urethral**	**Supra-pubic**
Circle Y or N as appropriate for each question		
1. Documentation - reason for Insertion and continued use is recorded	Y	N
2. Documentation - ease of insertion (i.e. no. of attempts) is recorded	Y	N
3. Catheter support in place e.g. tape, leg bag straps	Y	N
4. Drainage bag is no more than 3/4 full	Y	N
5. Drainage bag is not touching the floor	Y	N
6. Bag is below patient bladder	Y	N
7. Catheter & bag connections are secure	Y	N
8. Catheter & tubing are not kinked	Y	N
9. Has the patient been provided with information on the care of the catheter?	Y	N
Total score	**/ 9**	**/ 9**

Feedback/comment	**Score for compliance = ……%** $\frac{\text{total number of yes answers}}{\text{total number of questions}}$ x 100 = xx%

NSQHS Standard Criterion: Infection prevention and control systems

10. Audit: Ward compliance with implementation of standard precautions

Objective: To identify ward compliance with implementation of standard precautions

Links to SA Health resources:

Prevention and management of infection in healthcare settings.

EPA Waste and Recycling

Instructions for use: It is recommended that a sample of 5 to 10 ward areas are audited using this audit tool.

Y = ward is compliant with criteria; N = ward is not compliant with criteria
(Fill in Y or N as appropriate).

Ward or unit area: .....

Assessor: ..... Date: .....

Topic	Questions	Compliance	Comments
1. Hand Hygiene	**1.1.** There is a soap dispenser at every sink (these are not empty)		
	1.2. There are paper towels available at every sink		
	1.3. There are waste bins at every sink		
	1.4. Alcohol-based hand rub is available throughout the ward/unit		
	1. Sub-total	**/ 4**	
2. PPE	**2.1.** Non-sterile gloves available & readily accessible		
	2.2. Long sleeve gowns/aprons available & readily accessible		
	2.3. Protective eyewear available & readily accessible		
	2.4. Surgical masks available & readily accessible		
	2. Sub-total	**/ 4**	
3. Shared patient equipment	**3.1.** Detergent / detergent-disinfectant (wipes or solution) are available for cleaning of patient care equipment		
	3. Sub-total	**/ 1**	

Topic	Questions	Compliance	Comments
4. Linen (Also see Audit No.13)	**4.1.** Linen bags are not over filled e.g. linen bags are less than 3/4 full		
	4.2. Wet / leaking linen bags are placed in a plastic bag		
	4.3. Staff in the onsite laundry service have attended annual infection control education (view attendance records)		
	4.4. Clean linen trolleys are regularly cleaned and serviced (view cleaning schedule)		
	4.5. Soiled linen is stored in areas separate from the clean linen storage area		
	4.6. Laundered linen is stored on clean shelves and if necessary wrapped in a protective covering for transport		
	4. Sub-total	**/ 6**	
5. Clinical waste (previously known as medical waste)	**5.1.** Containers of medical waste are stored in a secure location		
	5.2. All necessary equipment required to clean & disinfect the area in case of accidental spillage is available & easily accessible		
	5.3. Medical waste is separated from general waste		
	5.4. There are adequate clinical waste bins in the ward/unit		
	5.5. Suitable containers are used as recommended by SA EPA Guidelines (Sep 2003)		
	5.6. Containers of medical waste are not overfull		
	5.7. There are signs at clinical waste bins to identify what items are suitable to discard		
	5. Sub-total	**/ 7**	

Topic	Questions	Compliance	Comments
6. General waste	**6.1.** There are adequate general waste bins in the ward/unit		
	6.2. General waste bins no more than 3/4 full		
	6. Sub-total	**/ 2**	
7. Consumer information	**7.1.** The ward/unit has consumer information displayed regarding infection prevention and control		
	7. Sub-total	**/ 1**	
	Combined total score	**/ 25**	

Feedback/comment	**Score for overall compliance = ……%** $\frac{\text{total number of yes answers}}{\text{total number of questions}}$ x 100 = xx%

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NSQHS Standard Criterion: Infection prevention and control systems

11. Audit: Ward compliance with implementation of standard precautions: safe management of sharps

Objective: To identify ward compliance with implementation of sharps safety practices

Instructions for use: It is recommended that a sample of 5 clinical staff (HCW) per area is assessed using the audit tool.

Y = ward is compliant with criteria; N = ward is not compliant with criteria
(Fill in Y or N as appropriate).

Ward or unit area: .....

Assessor: ..... Date: .....

General ward questions										Compliance	
Circle Y or N as appropriate											
1. Sharps disposal containers are not overflowing or overfilled i.e. must not be filled above the mark that indicates the maximum fill level.										Y	N
2. Sharps disposal containers are secured safely. If wall attached accessible height for HCW. Safe for consumers by being locked/ counterbalanced door and/or external cover or attached to a trolley/bench.										Y	N
3. Sharps are disposed of directly into a sharps disposal container at point of use										Y	N
4. Inappropriate re-sheathing of needles does not occur. **Observe 5 HCW**. (circle Y or N)											
HCW 1		**HCW 2**		**HCW 3**		**HCW 4**		**HCW 5**			
Y	N	Y	N	Y	N	Y	N	Y	N		
5. HCW is aware of the action required following a needlestick exposure. **Ask 5 HCWs**. (circle Y or N)											
HCW 1		**HCW 2**		**HCW 3**		**HCW 4**		**HCW 5**			
Y	N	Y	N	Y	N	Y	N	Y	N		
6. HCW can identify where to find information regarding the safe use of sharps. **Ask 5 HCW**. (circle Y or N)											
HCW 1		**HCW 2**		**HCW 3**		**HCW 4**		**HCW 5**			
Y	N	Y	N	Y	N	Y	N	Y	N		
									Total score	**/ 18**	
Feedback/comment										**Score for compliance = ……%** total number of yes answers x 100 = xx% total number of yes and no responses (e.g. if 5 HCW audited per questions 5, 6, 7 then total = 18)	

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NSQHS Standard Criterion: Infection prevention and control systems

12. Audit: Ward compliance with implementation of transmission-based precautions (TBP)

Objective: To identify ward compliance with implementation of transmission-based precautions

Ward or unit area: .....

Assessor: ..... Date: .....

Instructions for use: It is recommended that a sample of between 1 and 5 patients on TBP per ward area are assessed using the audit tool.

Randomly select 1 to 5 patients, one sheet per ward (Fill in Y or N as appropriate).

Question	Pt. 1	Pt. 2	Pt. 3	Pt. 4	Pt. 5	Comments
Compliance (Y or N)						
1. HCW caring for the patient is aware of why their patient is in TBP and can state the infection / organism (ask patient care clinician)						
2. Is TBP necessary i.e. does the patient remain infectious?						
3. Patient is placed in a single room (as appropriate)						
4. For airborne precautions ONLY – patient is in a negative pressure room with door shut						
5. Are bathroom facilities appropriate? (i.e. ensuite, dedicated commode or bathroom)						
6. Is the correct transmission-based precaution signage displayed?						
7. Is the required PPE available –						
7.1 non-sterile gloves						
7.2 disposable long sleeve gowns/plastic aprons						
7.3 masks (surgical for droplet or P2/N95 for airborne)						

Question	Pt. 1	Pt. 2	Pt. 3	Pt. 4	Pt. 5	Comments
Compliance (Y or N)						
7.4 eye protection (safety glasses/goggles/face shields)						
8. Is PPE properly discarded upon leaving the room?						
9. Has a relevant alert been documented implemented (electronic, case-note, other local procedure or system?						
10. Appropriate daily cleaning is conducted (detergent + disinfectant)						
11. Has the patient/consumer been provided with information regarding their care management e.g. VRE, MRSA, influenza						
Total Score	**/13**	**/13**	**/13**	**/13**	**/13**	

Feedback/comment:	**Score for compliance = ……%** $\frac{\text{total number of yes answers}}{\text{total number of questions}}$ x 100 = xx%

NSQHS Standard Criterion: Infection prevention and control systems

13. Audit: Laundry practices

Objective: Practices meet Australian Standard AS/NZS 4146: 2000 *Laundry practice*

To monitor the processes and practices of the laundry to ensure relevant Australian Standards are met.
(Applicable to those SA Health facilities with in-house laundry services)

Ward or unit area: .....

Assessor: ..... Date: .....

Instructions for use: Use one audit sheet per audit.

Y = staff member or laundry service complies, N = staff member or laundry service does not comply.

Questions		Compliance	
Circle Y or N as appropriate			
1.	Appropriate protective clothing is worn, i.e. gloves and gowns when handling soiled linen.	Y	N
2.	Staff in the laundry service have attended annual infection control education (view attendance records)	Y	N
3.	Linen trolleys are regularly cleaned and serviced. (view cleaning schedule)	Y	N
4.	Soiled linen is stored in areas separate from the clean linen storage area	Y	N
5.	Laundered linen is stored on clean shelves and if necessary, wrapped in a protective covering	Y	N
6.	Operating theatre linen is inspected for staining and damage. (view records) **Note:** Do not answer or include this question if no operating theatre linen at the site	Y	N
7.	Records are kept of each wash parameters (type of linen washed, maximum wash load, wash program or process, duration of each operation, water level, water temperature, chemicals and their dosage, machine type and other relevant information	Y	N
8.	Records are kept for all relevant tests as specified in Sections 2.2 to 3.6.4 including requirements as per 3.5.2 (Thermal) and 3.5.3 (Chemical disinfection) of AS/NZS 4146:2000.	Y	N
	Total Score	**/ 8**	
Feedback/comment:	**Score for compliance = …… %** $\frac{\text{total number of yes answers}}{\text{total number of questions}}$ x 100 = xx%		

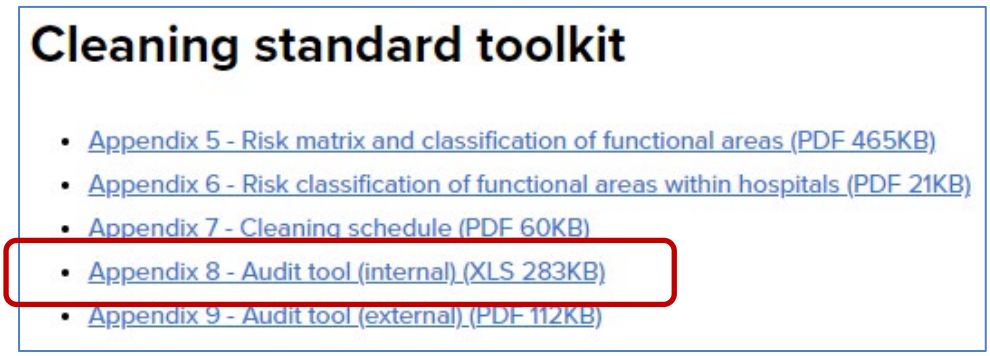
NSQHS Standard Criterion: Infection prevention and control systems

14. Audit: Cleaning practices

Objective: **To identify LHN compliance with the SA Health *Cleaning Standard for Healthcare Facilities***

To monitor the processes and practices detailed in the SA Health Cleaning Standard are met.

Refer to the SA Health Cleaning Standard Toolkit



Cleaning standard toolkit

- Appendix 5 - Risk matrix and classification of functional areas (PDF 465KB)
- Appendix 6 - Risk classification of functional areas within hospitals (PDF 21KB)
- Appendix 7 - Cleaning schedule (PDF 60KB)
- Appendix 8 - Audit tool (internal) (XLS 283KB)
- Appendix 9 - Audit tool (external) (PDF 112KB)

NSQHS Standard Criterion: Infection prevention and control systems

15. Audit: Neonatal ward compliance with implementation of standard precautions

Objective: **To identify ward compliance with implementation of standard precautions**

Ward or unit area: .....

Assessor: ..... Date: .....

Instructions for use: It is recommended that a sample of 5 to 10 ward areas are audited using this audit tool.

Y = ward is compliant with criteria; N = ward is not compliant with criteria; N/A = not applicable
(Fill in Y or N or N/A as appropriate).

Topic	Questions	Compliance	Comments
1. Hand Hygiene	**1.1.** There is a soap dispenser at every sink (not empty)		
	1.2. There are paper towels available at every sink		
	1.3. There are waste bins at every sink		
	1.4. Alcohol-based hand rub is available in the patient zone* (see also Audit No. 4) *At the end of each bed or immediately near if unable to be placed on the end of the bed		
	1.5. Staff with skin concerns have been assessed by WHS		
	1.6. Staff who are exempt from soap use have individual wash		
	1. Sub-total	**/ 6**	
2. Bare below the elbows (See also Audit No.5)	**2.1.** Staff are not wearing long sleeves		
	2.2. Staff are not wearing jewellery / watch ***Note***: plain ring & Medic Alert bracelets exempt		
	2.3. Staff nails are clean and short, and no nail polish or artificial nails		
	2 Sub-total	**/ 3**	
3. PPE	**3.1.** Non-sterile gloves available & readily accessible		
	3.2. Disposable aprons available & readily accessible		
	3.3. Long sleeve gowns/aprons available & readily accessible		
	3.4. Protective eyewear available & readily accessible		

Topic	Questions	Compliance	Comments
	3.5. Surgical masks available & readily accessible		
	3. Sub-total	**/ 5**	
4. Linen	**4.1.** Linen bags are no more than 3/4 full		
	4.2. Wet / leaking linen bags are placed in a plastic bag (may be marked N/A if not seen when auditing)		
	4.3. Soiled linen is stored in areas separate from the clean linen storage area		
	4.4. Laundered linen is stored on clean shelves with a protective covering		
	4. Sub-total	**/ 4**	
5. General waste	**5.1.** There are adequate general waste bins in the ward/unit (each patient room and treatment area)		
	5.2. General waste bins are no more than 3/4 full		
	5. Sub-total	**/ 2**	
6. Clinical waste (previously known as medical waste)	**6.1.** Containers of clinical waste are stored in a secure location (away from public access)		
	6.2. Spill kits available and accessible		
	6.3. Clinical waste bins are no more than 3/4 full		
	6.4. Signage displayed to identify appropriate items to discard in clinical waste		
	6. Sub-total	**/ 4**	

Topic	Questions	Compliance	Comments
7. Shared patient equipment	**7.1.** Detergent / detergent-disinfectant (wipes or solution) are available for cleaning of patient care equipment		
	7.2. Baths are cleaned between use		
	7.3. Breast pumps are cleaned between use		
	7.4. Breast pump accessories are not cleaned in hand hygiene sinks		
	7.5. Pacifiers are reprocessed as per local procedures		
	7.6. Pacifiers are reprocessed as per the AS/NZS 5369:2023 *Reprocessing of reusable medical devices in health service organisations*		
	7.7. Baby wash solution is single patient use		
	7.8. Stethoscopes are designated or cleaned and disinfected between use		
	7.9. Thermometers are designated or cleaned and disinfected between use		
	7.10. Cots/cribs cleaned and disinfected between use		
	7.11. Crib filters are changed as per manufacturer's instructions		
	7.12. Sterile water is used for humidified cribs		
	7.13. Cot mattresses are in good repair		
	7.14. Ultrasound gel is single use		
	7.15. Audiology assessment equipment is cleaned between use		
	7.16. Eye assessment equipment is single use or reprocessed accordingly to manufacturer's instructions		
	7.17. Portable computers have a regular cleaning schedule		
	7.18. Are washing machines used in the area		

Topic	Questions	Compliance	Comments
	7.19. If used, does the washing machine meet the AS/NZS 4146:2000 *Laundry Practice*		
	7. Sub-total	**/ 19**	
8. Transmission-based precautions (TBP)	**8.1.** Is the correct TBP signage displayed		
	8. Sub-total	**/ 1**	
9. Environment	**9.1.** Patient rooms are free from clutter and in good repair		
	9.2. Corridors are free from clutter and in good repair		
	9.3. Dirty utility room free from clutter and in good repair		
	9.4. Dirty utility room has a clean / dirty flow		
	9.5. Daily clean completed using detergent & disinfectant e.g. sodium hypochlorite 1,000 ppm solution		
	9.6. Discharge clean completed using detergent & disinfectant e.g. sodium hypochlorite 1,000 ppm solution		
	9.7. Is the clean performed by PSA / cleaning staff		
	9.8. Gloves changed between individual patient pods / areas		
	9.9. Cleaning cloth changed between individual patient pods / area		
	9.10. PSA/Cleaning staff have received training		
	9.11. Mop changed between patient rooms		
	9.12. Sterile stock is stored as per the AS/NZS 5369:2023 *Reprocessing of reusable medical devices in health service organisations*		
	9. Sub-total	**/ 12**	

Topic	Questions	Compliance	Comments
10. Hand hygiene sinks	**10.1.** No aerators in taps		
	10.2. Annual thermostatic mixing valve (TMV) maintenance is performed		
	10.3. No waste products are discarded in sink, i.e. wash water, breast milk		
	10.4. No washing of reusable equipment in sink (i.e. bowls, breast pump equipment)		
	10. Sub-total	**/ 4**	
11. Clinical Practices	**11.1.** Shared medications are not used		
	11.2. Eye toilets are performed using sterile water		
	11.3. Mouth toilets are performed using sterile water		
	11. Sub-total	**/ 3**	
12. Communal room	**12.1.** Communal room has cleaning schedule in place		
	12.2. Hand hygiene facilities are available		
	12.3. Surfaces / chairs can be wiped		
	12. Sub-total	**/ 3**	
13. Milk room	**13.1.** Are operating procedures in place		
	13. Sub-total	**/ 1**	
14. Policy and procedures	**14.1.** Are specific policies and procedures are up-to-date and include relevant infection control requirements		
	14. Sub-total	**/ 1**	
15. Infection control liaison (ICLN)	**15.1.** There is a nominated Infection Control Link Nurse (ICLN) representation		
	15. Sub-total	**/ 1**	

Topic	Questions	Compliance	Comments
16. Consumer information	**16.1.** Visitors / parents are educated on hand hygiene requirements		
	16.2. Parents are educated on the use of hand hygiene sinks		
	16.3. Parents are educated on the use of shared equipment		
	16. Sub-total	**/ 3**	
		Total score	**/ 72**

Feedback/comment:	**Score for compliance = ……%** $\frac{\text{total number of yes answers}}{\text{total number of yes and no responses}}$ x 100 = xx%

NSQHS Standard Criterion: Reprocessing of reusable equipment and devices

16. Audit: Storage of sterile stock

Objective: **Ward/clinical areas practices meet Australian Standard AS/NZS 5369:2023 (outside the scope of the Sterilisation Department and theatre sterile store)**

Instructions for use: It is recommended that a sample of between 5 and 10 storage areas are audited using the audit tool, (one area per audit sheet)**.**

Ward or unit area: .....

Assessor: ..... Date: .....

Questions	Compliance	
Circle Y or N as appropriate		
1. Is sterile stock stored on or in designated shelving, cupboards, drawers or containers	Y	N
2. Access to sterile store area is restricted to those who have an adequate understanding in handling sterilised items e.g. in-service training	Y	N
3. Is clear signage present to identify sterile stock storage area?	Y	N
4. Are hand washing facilities / Alcohol Based Hand Rub (ABHR) available at or near the sterile storage location?	Y	N
5. The storage area is visibly clean and enables the floor area to be cleaned without environmental contamination of sterile stock.	Y	N
6. The sterile stock is stored where there isn't potential for temperature increase close to lighting / ceiling	Y	N
7. Are Items protected from direct sunlight and dust?	Y	N
8. Walls, floors and work surfaces are constructed so that difficult-to-clean corners are minimized and surfaces are non-porous, smooth and easily cleaned	Y	N
9. Is there a cleaning program in place for the storage area?	Y	N
10. Are storage containers kept clean, dry and in good condition?	Y	N
11. Is there a cleaning program in place for the storage containers?	Y	N
12. Cardboard boxes (excluding dispenser boxes) are NOT used as storage containers for items sterilised in the healthcare facility. (porous, cannot be adequately cleaned and may harbour organisms)	Y	N
13. Commercial dispenser boxes are disposed of when empty and not topped up or reused	Y	N
14. Is sterile stock that is delivered after hours stored correctly?	Y	N

Questions	Compliance	
Circle Y or N as appropriate		
15. Sterile stock is placed in a manner that does not compromise the integrity of the items eg. stock is not tightly packed into storage containers or shelving, or wrapped with elastic bands, sticky tape etc.	Y	N
16. Staff can describe the general requirements for identifying the safe use of a conforming sterile pack: a) Within expiry date (if applicable)	Y	N
b) Indicator on the pack has changed to the correct colour	Y	N
c) Pack is intact and visibly clean, i.e. no holes or tears, no water marks, no dust present	Y	N
d) No additional writing is on the pack (excludes CSSD labelling)	Y	N
e) Batch label identifying sterilisation details is present	Y	N
17. There is a system for stock rotation based on sterilisation date. (Auditor to spot check dates are in order and evaluate staff understanding) For example ask a staff member where to take stock from when required i.e. take from right hand side, front, top	Y	N
18. There is a procedure for identification and management of items that are identified as non-conforming to sterile pack requirements to ensure they are not used e.g. a torn pack in the sterile stock storage area	Y	N
19. Ask staff to explain the correct procedure for removing non-conforming stock from the area	Y	N
20. Was any non-conforming stock identified during the audit? If so, follow correct procedure for removal and advise area manager	Y	N
Total score	**/ 24**	

Feedback/comment:	**Score for compliance = …… %** $\frac{\text{total number of yes answers}}{\text{total number of questions}}$ x 100 = xx%

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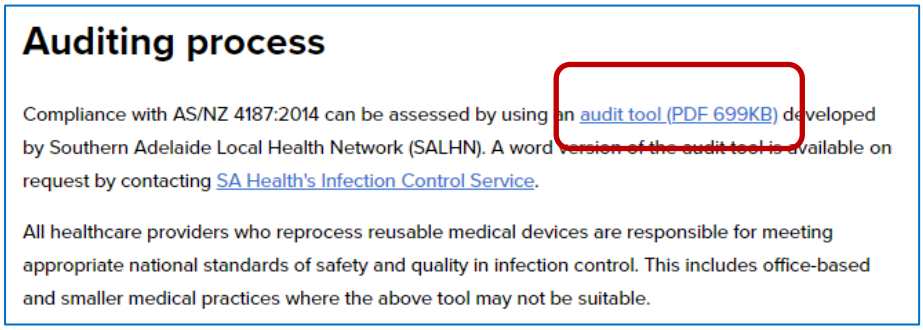
NSQHS Standard Criteria: Reprocessing of reusable medical devices

17. Audit: Sterilisation and reprocessing practices

Objective: **LHN practices meet Australian Standard AS/NZS 5369:2023**

Refer to the Southern Adelaide Local Health Network AS/NZS 4187 Audit Tool



Auditing process

Compliance with AS/NZ 4187:2014 can be assessed by using an audit tool (PDF 699KB) developed by Southern Adelaide Local Health Network (SALHN). A word version of the audit tool is available on request by contacting SA Health's Infection Control Service.

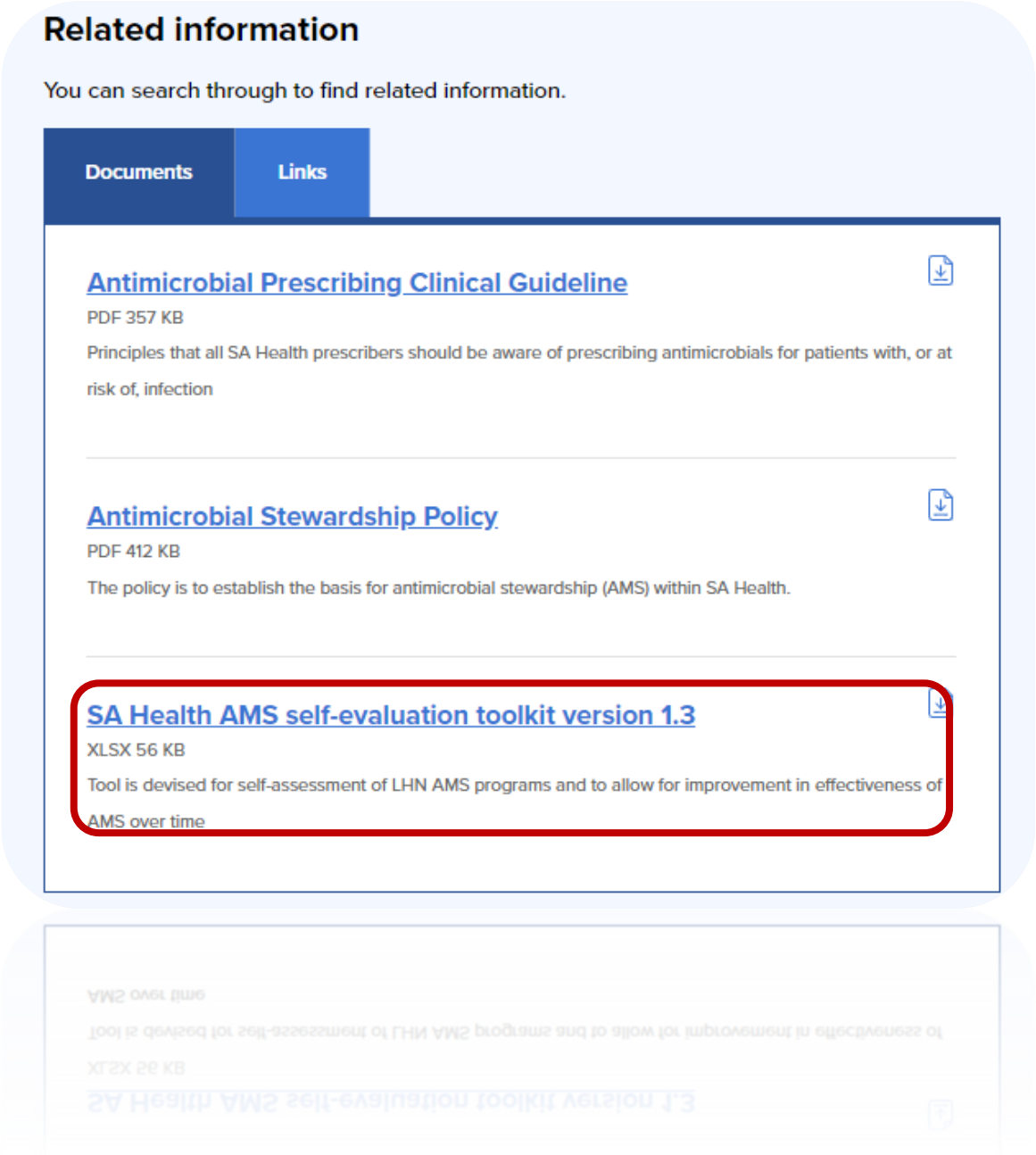
All healthcare providers who reprocess reusable medical devices are responsible for meeting appropriate national standards of safety and quality in infection control. This includes office-based and smaller medical practices where the above tool may not be suitable.

NSQHS Standard Criterion: Clinical governance and quality improvement systems are in place to prevent and control infections, and support antimicrobial stewardship and sustainable use of infection prevention and control resources

18. Audit: AMS self-evaluation tool

Objective: **To monitor improvements in effectiveness of antimicrobial stewardship programs and adherence to the SA Health Antimicrobial Stewardship Procedures**

Refer to the SA Health Antimicrobial Stewardship Program: Self-evaluation toolkit (see Related information section)



NSQHS Standard Criterion: Antimicrobial stewardship

19. Audit: National Antimicrobial Prescribing Surveys (NAPS)

Objective: **To monitor improvements in effectiveness of antimicrobial stewardship programs**

Refer to the National Centre for Antimicrobial Stewardship webpage

Version control and change history

Version	Date from	Date to	Amendment
2.6	17/01/2024	17/01/2026	Minor updates. Update to AS/NZS 5369:2023
2.5	22/11/23	22/11/25	Minor updates including updated introduction and removal of mapping to specific criteria within the NSQHS Standards
2.4	5/04/2022	22/11/23	Minor updates
2.3	7/10/2020	5/04/2022	Add new audit (NICU related)
2.2	12/4/2019	7/10/2020	Minor alteration
2.1	30/1/2019	12/4/2019	Minor alteration
2.0	18/12/2018	30/1/2019	Update references to the NSQHS Standards 2nd edition and additional audits
1.1	11/05/2016	18/12/2018	Minor alteration
1.0	June 2015	11/05/2016	Original version

For more information

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www.sahealth.sa.gov.au/infectionprevention

www.ausgoal.gov.au/creative-commons

Government of South Australia

SA Health